

**Who Chooses the Appropriate Treatment for Hyperhidrosis—Physician and Patient, or Insurer?**

To the Editor: Hyperhidrosis (excessive sweating beyond that required for body temperature regulation) has become a more familiar term to the public because of increased awareness of this problem as a “real” entity and the availability of information on the Internet. In the May 2005 issue of *Mayo Clinic Proceedings*, Eisenach et al<sup>1</sup> reviewed therapies for this problem. They discussed conservative methods to deal with palmar hyperhidrosis, including botulinum toxin, but noted that in severe cases these treatments often fail or have only short-term effects. For patients with severe hyperhidrosis, endoscopic thoracic sympathectomy (ETS) has become the treatment of choice.

A PubMed search for the terms *sympathectomy* and *hyperhidrosis* yielded more than 600 articles dating back as far as the 1950s, with more than 50 specifically on ETS for hyperhidrosis from 1992 to 2005. These published studies represent thousands of cases. Endoscopic thoracic sympathectomy can stop palmar sweating in at least 98% of patients, and the recurrence rate is no more than 1% to 2%.<sup>2,3</sup> All patients develop some compensatory sweating after ETS, but in most it is mild to moderate, with only 3% to 5% of patients expressing dissatisfaction with the outcome.<sup>2,3</sup>

Despite this record for ETS, many insurance carriers are now demanding that patients undergo treatment with BOTOX (Allergan, Inc, Irvine, Calif), a botulinum toxin type A, before they will consider authorization for an operation. According to the manufacturer, BOTOX is indicated for the treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents. In such patients, it can stop the axillary sweating for a certain period, usually no more than 12 months and sometimes less than 4 months. Then, injections need to be repeated. It is not Food and Drug Administration–approved for the treatment of palmar hyperhidrosis. A recent review article, in which the first author and 2 others cited conflict of interest because they have received research grants and consultant payments from Allergan, indicated that several studies have shown efficacy with botulinum toxin type A in the suppression of axillary hyperhidrosis, and they cited 4 studies (3 from their group).<sup>4</sup> For palmar hyperhidrosis, they cite 3 studies; 2 with 20 patients and 1 with 19 patients. They conclude, “There is more inconsistency in the treatment of palmar hyperhidrosis than in axillary hyperhidrosis and currently no license exists for botulinum toxin in the treatment of palmar hyperhidrosis.” They also note that giving botulinum toxin type A injections through the densely innervated skin of the palms is often painful and can deter patients from repeated treatments. Therefore, they recommend regional blocking of the ulnar and median nerves at the wrist with lidocaine before administering botulinum toxin injections. Moreover, there have been reports of reversible minor weakness in the hands after botulinum toxin treatment, lasting from 3 to 5 weeks. BOTOX is not an inexpensive treatment, and the

expense increases if a nerve block is also performed. The need for repeated treatments, even 2 or 3, makes it likely to be far more expensive than ETS, which is a permanent solution.

Patients who have severe primary hyperhidrosis should most certainly try 1 or 2 conservative methods before undergoing any surgical intervention. Patients do not view a surgical procedure lightly. Therefore, it is extremely disturbing to see insurance carriers demanding that patients try any of these conservative methods for lengthy periods if they fail to help patients. This only prolongs the pain (certainly with botulinum toxin), discomfort, and feelings of futility. To allow the insurance industry to decide that patients must first try an unapproved (by the Food and Drug Administration) and unproven treatment for palmar hyperhidrosis before undergoing treatment that has been shown to be effective, that is in widespread use, and for which results have been published on thousands of patients should be unacceptable to the medical profession.

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1. Eisenach JH, Atkinson JLD, Fealey RD. Hyperhidrosis: evolving therapies for a well-established phenomenon. *Mayo Clin Proc.* 2005;80:657-666.
2. Reisfeld R, Nguyen R, Pnini A. Endoscopic thoracic sympathectomy for treatment of essential hyperhidrosis syndrome: experience with 650 patients. *Surg Laparosc Endosc Percutan Tech.* 2000;10:5-10.
3. Reisfeld R, Nguyen R, Pnini A. Endoscopic thoracic sympathectomy for hyperhidrosis: experience with both cauterization and clamping methods. *Surg Laparosc Endosc Percutan Tech.* 2002;12:255-267.
4. Lowe N, Campanati A, Bodokh I, et al. The place of botulinum toxin type A in the treatment of focal hyperhidrosis. *Br J Dermatol.* 2004;151:1115-1122

In reply: We appreciate the points made by Dr Reisfeld. We attempted to describe current therapies without insinuations of superiority or bias because of the heterogeneity of hyperhidrosis and, more importantly, because the evidence comparing specific therapies is currently insufficient. Treatment progresses in order of invasiveness, risk-to-benefit, and cost. We wholly agree with the seriousness of insurers requiring multiple steps in the treatment approach that are off-label and unproved, particularly for palmar hyperhidrosis. In our experience, treatment of palmar hyperhidrosis with botulinum toxin has been presented as an option—not a requirement—by patient insurers. If botulinum injection for palmar hyperhidrosis is indeed less effective, less satisfying, and more costly than endoscopic sympathectomy surgery, physicians, patients, and insurers will adjust accordingly. Debate between repeated medical therapy and permanent surgical therapy is certainly not unique to this disorder and will require prospective trials to promulgate evidence-based medicine instead of opinion.

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